



Kentucky Personnel Cabinet  
501 High Street  
Frankfort, KY 40601

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**IC MEMORANDUM 14-01**

TO: Non-Commonwealth Paid Insurance Coordinators (ICs)  
Human Resources Generalists (HRGs)  
Billing Liaisons

FROM: Kentucky Group Life Insurance (KGLI)

SUBJECT: KGLI Open Enrollment, NEW Plans and Rates

DATE: September 15, 2014

Nationwide Life Insurance Company, via competitive bid, was awarded a new contract beginning January 1, 2015. As a result, Kentucky Group Life Insurance will offer a Life Insurance Open Enrollment to our members via the KHRIS Employee Self-Service/ESS portal.

Members, including KEHP cross-reference participants, wishing to add or change existing coverage may do so during this Open Enrollment period. **This year, life insurance Open Enrollment is optional; health insurance Open Enrollment is mandatory. Employees satisfied with existing coverage will not have to re-enroll.** Coverage will be effective January 1, 2015.

**Two NEW state-sponsored plans of \$25,000 and \$50,000 will be available during this time, in addition to all Optional and Dependent plans currently offered.**

There are minor rate changes for Optional coverage. Optional coverage for those under 40 will be \$0.24 per thousand; over 60, \$0.98 per thousand. All other Optional and Dependent rates remain the same. The 2015-2016 Basic Premium Rate (employer provided \$20,000) will be \$0.80.

The policy for cancelling coverage remains the same and all cancellation requests will be processed by KGLI. Requests must be signed and dated by the member. Also, please utilize HRBEN0074 reporting to assist and answer questions from employees related to current coverage levels, as well as future deductions related to Open Enrollment.

Employees will receive a separate notification concerning Open Enrollment on the afternoon of September 15, 2014.

For additional information please contact Kentucky Group Life Insurance at 1-800-267-8352 or visit our [website](#).

Note: Life Insurance Open Enrollment form is available on our site.



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For additional information please contact Kentucky Group Life Insurance at 1-800-267-8352.



**Nationwide Life  
Insurance Company**  
Home Office: Columbus, Ohio

Commonwealth of Kentucky  
Employee Group Life Insurance Program  
**Open Enrollment Form**  
**Group Insurance Contract: BE 0002**

### OPEN ENROLLMENT -- SELECTIONS EFFECTIVE 1/1/2015

SSN		Location Name (Specify name or Agency, School Board or Health Dept.)			
Name (Last, First, MI)		Location Number		Birth date	
Address (Street Name/Number)	Annual Salary	Hire Date		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
(City, County, State, Zip)	Work Number		Home Number		

**A. Basic Life and Accidental Death and Dismemberment (AD&D) Insurance**

Eligible employees are insured at no cost to the employee for Basic Life and AD&D Insurance  
All Eligible Employees \$20,000 Cost: (employer paid)

**B. Optional Life and Accidental Death and Dismemberment (AD&D) Insurance (Select One Plan)**

I wish to \_\_\_\_\_ enroll\* in, \_\_\_\_\_ change\* to the optional insurance plan checked below: **(Select one plan only)**

Age Band	Rate per \$1,000
Under 40	<b>\$0.24</b>
40-59	\$0.60
60 and over	<b>\$0.98</b>

<input type="checkbox"/> Plan 1 \$5,000	<input type="checkbox"/> Plan 3 (NEW) <b>\$25,000</b>	<input type="checkbox"/> Plan 5 1X Annual Salary**
<input type="checkbox"/> Plan 2 \$10,000	<input type="checkbox"/> Plan 4 (NEW) <b>\$50,000</b>	<input type="checkbox"/> Plan 6 2X Annual Salary**

\*Evidence of insurability may be required depending on the circumstances and/or for insurance over \$150,000.

\*\*Under Plans 5 and 6, insurance amounts will be rounded to the nearest multiple of \$1,000. Amounts of insurance will increase with an earnings change.

**C. Dependent Life Insurance (Select One Plan)**

Please \_\_\_\_\_ enroll\* my dependents in, \_\_\_\_\_ change\* my present plan to the plan checked below: **(Select one plan only)**

	<input type="checkbox"/> Plan A	<input type="checkbox"/> Plan B	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan D	<input type="checkbox"/> Plan E
Spouse**	\$10,000	\$5,000	\$5,000	\$10,000	---
Dependent Children to 6 mos	\$2,500	\$1,500	---	---	\$2,500
Dependent Children 6 mos to 18 yrs***	\$5,000	\$3,000	---	---	\$5,000
<b>Monthly Contribution</b>	\$11.46	\$6.20	\$2.62	\$9.14	\$3.78

\*Evidence of insurability may be required depending on circumstances

\*\* Spouse means a person to whom you are legally married

\*\*\* 18 and older if attending an educational institution and relying on the employee for financial support

**D. Fraud Warning:** Any Person who knowingly and with intent to injure, defraud, or deceive an insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss of benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

**E. Employee Signature and Date (Required)**

I, the undersigned, certify that I have read the completed enrollment/change/termination form and agree that all answers in this form are true and complete to the best of my knowledge and belief. I hereby authorize my employer to deduct from my paycheck or earnings the amount required to cover my share of the coverage I have selected.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

IC/HRG Signature \_\_\_\_\_

Date \_\_\_\_\_

Send Copy to your Insurance Coordinator

## Instructions

- Print all information using black or blue ink (if submitting a paper form.)
- Complete location name and number.
- Annual earnings are required when selecting Optional Plan 3 or 4.
- Select only one plan for Optional Term Life coverage.
- Select only one plan for Dependent Term Life coverage.
- Employee must provide evidence of insurability for coverage over \$150,000. This must be approved by the insurance carrier before coverage can be initiated.
- Spouse is defined as a person to whom you are legally married.
- Child 18 or older can remain covered providing the child is a full-time student and relying on the *employee for financial support*.
- Employee signature and date is required (if submitting a paper form.)
- Insurance Coordinator should *verify all information* in ESS, or sign and date form.
- Description of Qualifying Event should be completed by the Insurance Coordinator. For example: Marriage only.
- Date of Qualifying Event should be listed as the last day employee worked or official date of termination, not when coverage will end.

For Board of Education employees with salary based plans, the new contract year salary will be effective 11/1 of each year.

Premium rates are effective as of January 1, 2015. Rates may change as the insured enters a higher age category or if the plan experience requires a change for all insured.



# Nationwide Life Insurance Company

Nationwide Employee Benefits <sup>SM</sup>

Group Life and Accidental Death

Submit Form to: Personnel Cabinet- Group Life Administration, 501 High Street, 3<sup>rd</sup> Flr, Frankfort, KY 40601

*On Your Side®*

## Section 1: Insured Information (Please complete all appropriate boxes in ink, printing legibly.)

Group Name <b>Commonwealth of Kentucky</b>	Group Number <b>90002</b>
Employee Name (First, Middle Initial, Last)	Social Security Number
Subject to the terms and conditions of the above referenced Group Number, I request that any sum becoming payable by reason of my death be payable to the following beneficiary (ies). It is my understanding that this designation shall operate so as to revoke all designations of beneficiary (ies) previously made by me under the Group Policy.	
Employee Signature (Required)	Date (Required)

Note: Beneficiary designation is not valid unless this form and any separate accompanying sheets are signed and dated.

## Section 2: Beneficiary Designation/Change (Please complete all appropriate boxes in ink, printing legibly. If you do not designate one or more beneficiaries, policy proceeds will be paid to your estate unless otherwise regulated by law.)

Basic Life and AD&D				
Primary Beneficiary Information (Allocation to all Primary Beneficiaries must equal 100%)				
Beneficiary Name and Address	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit
Contingent Beneficiary Information (Allocation to Contingent Beneficiaries must equal 100%)				
Beneficiary Name and Address	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit

## Optional Life and AD&D

Primary Beneficiary Information (Allocation to all Primary Beneficiaries must equal 100%)				
Beneficiary Name and Address	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit
Contingent Beneficiary Information (Allocation to Contingent Beneficiaries must equal 100%)				
Beneficiary Name and Address	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit

## Section 3: General Information

- If more room is needed to indicate additional primary or contingent beneficiaries, please attach a separate sheet and list the information indicated above for each beneficiary. Please sign and date all additional sheets as well as this original form.
- Your group life coverage is issued by Nationwide Life Insurance Company, One Nationwide Plaza, MR-05-11 Columbus, OH 43215. Please refer to the Certificate of Insurance and Insurance Contract for all plan details, including any exclusions, limitations and restrictions which may apply.

Designation of Beneficiary (may be completed on-line using KHRIS Employee Self Service Center)

Instructions

- Print all information using black or blue ink.
- If additional space is needed, a separate paper listing all beneficiary information may be included. This paper must be signed and dated the same as the original form.
- Complete location name.
- Employee signature and date is required.
- Include the relationship of the beneficiary to the employee and the percentage of benefit to be paid.
- One or more beneficiaries may be named. If you do not name a beneficiary, or if you are not survived by one, benefits payable because of your death will be paid in equal shares to the first surviving class of the following: (a) Your spouse, (b) Your children, (c) Your parents, (d) Your brothers and sisters, and (e) Your estate. If utilizing KHRIS ESS, the Designation of Beneficiary will be effective immediately upon submission. If utilizing the paper form, the Designation of Beneficiary is not valid unless the form is signed and dated.
- The Designation of Beneficiary must be on file with your Employer and/or Life Insurance Branch at the time of your death to be accepted. KHRIS requires that all percentages be whole numbers. For example, an employee can no longer list 3 beneficiaries at 33 1/3% each. It must be entered as 33%, 33% and 34%. The percentages shall total 100%. Beneficiaries may be named or changed at any time without the consent of a beneficiary.
- If a trust or trustee is named beneficiary, the written trust must be identified in the beneficiary designation. For example, "Dorothy Q. Public, Trustee under the trust agreement dates \_\_\_\_." Show name and address of the trustee and effective date of the trust agreement.
- Insurance Coordinator should *verify all information*.

## **Optional Employee Life Insurance (effective 01/01/15)**

Optional Life Plan 1  
\$5,000

Optional Life Plan 3 **(NEW)**  
\$25,000

Optional Life Plan 5  
1X Annual Salary

Optional Life Plan 2  
\$10,000

Optional Life Plan 4 **(NEW)**  
\$50,000

Optional Life Plan 6  
2X Annual Salary

The cost of each plan is based on age.

	Under 40	40 – 59	Over 60
<b>Monthly Premium</b>	.24 per \$1,000	.60 per \$1,000	.98 per \$1,000

The amount of accidental death and dismemberment is an amount equal to the optional insurance amount.

Evidence of insurability may be required for insurance over \$150,000.

**Salary Increases and Decreases:** If you receive a pay increase after you enroll in Optional Life Insurance Plan 5 or Plan 6, your plan Coverage amount will automatically adjust to correspond with your salary increase. Your insurance Premium will automatically adjust to correspond with your increase in coverage as well. If you are a Commonwealth-paid employee, this increase will occur automatically through an automated process in the Kentucky Human Resources Information System (KHRIS) upon the effective date of your new salary.

For **Board of Education** employees with salary based plans, the new contract year salary will be effective 11/1 of each year.

For **Health Department and Quasi agency** employees with salary based plans, please verify that your HR Administrator is maintaining your current salary.

## **Dependent Coverage (effective 01/01/15)**

	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b> (spouse only)	<b>Plan D</b> (spouse only)	<b>Plan E</b> (children only)
Spouse	\$10,000	\$5,000	\$5,000	\$10,000	
Child to age 6 months	\$2,500	\$1,500			\$2,500
Child 6 months to 18 years; older if attending an educational institution and relying on the employee for financial support or if incapacitated and proof is received within 31 days of the 18-year age limit.	\$5,000	\$3,000			\$5,000
<b>Monthly Premium</b>	\$11.46	\$6.20	\$2.62	\$9.14	\$3.78